

### CONFIDENTIAL CASE HISTORY

Name: \_\_\_\_\_ CareCard #: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Date of Birth: M: \_\_\_ D: \_\_\_ Y: \_\_\_ Medical Doctor: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

**Reason seeking treatment->**Describe condition: \_\_\_\_\_

Onset:  Sudden  Gradual --Date of initial onset? \_\_\_\_\_

Cause of injury (if known): \_\_\_\_\_

Quality of pain:  Sharp  Burning  Dull  Aching  Tingling  Shooting  Other \_\_\_\_\_

What aggravates your symptoms? \_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_

Does your condition affect your daily activities?  No  Yes -> How? \_\_\_\_\_

Is the pain worse in the morning or the evening? \_\_\_\_\_

Are you currently seeing, or have you in the past, seen another practitioner for this condition?

Massage Therapy  Chiropractic  Physiotherapy  M.D.  Other: \_\_\_\_\_

Do you have any other areas of pain? \_\_\_\_\_

Have you had any serious injuries, accidents, surgery, illness? Please explain: \_\_\_\_\_

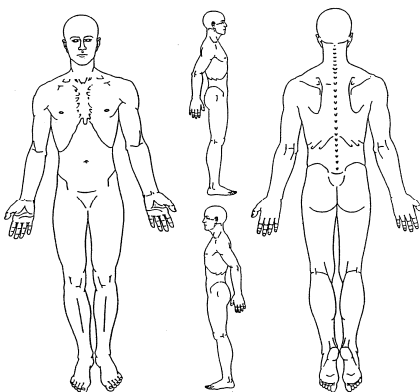
Do you engage in a fitness program?  No  Yes. Please describe (type of exercise/how often): \_\_\_\_\_

How would you describe your general health? Excellent Good Fair Poor

How would you rate your stress levels? Low< 0-----2-----4-----6-----8-----10 > High

Do you sleep well at night?  No  Yes. Average # of hours? \_\_\_\_\_

Please indicate areas of concern:



## Medical History

	Present	Past		Present	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Condition	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Aching joints	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hyperkyphosis	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycaemia	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlordosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Sprains/Strains	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Condition	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	GI Problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ear aches/ringing	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>	Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Allergies (please list)

\_\_\_\_\_

Do you have or use:  arch supports/orthotics  steel pins/plates  prosthetics

List medications: \_\_\_\_\_

To the best of my knowledge the above is a true statement of my physical condition,

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Cancellation Policy

Please keep in mind that your treatment time is reserved specifically for you. A minimum of 24 hours notice for rescheduling or canceling appointments is required. There will be a charge of the full scheduled treatment rate for missed appointments or cancellations without 24 hours notice.

Please initial here to indicate you have read & understood this policy. \_\_\_\_\_